RIDGE PHYSICAL THERAPY & WELLNESS CENTER

Insurance Intake Form

Major Medical Billing Information

Major health insurance carrier: _____

SEE COPIES OF CARDS FOR DETAILS

Worker's Compensation Injury Billing Information (if applicable)

Complete information is needed in order to process your claim.

Name of employer: _____

(see intake form for further employer information)

Worker's compensation insurance carrier: _____

Address of carrier: _____
street city state zip

Adjuster's name: _____ Adjuster's phone: _____

Claim #: _____

Auto Accident Injury Billing Information (if applicable)

Complete information is needed in order to process your claim.

Name of no-fault insurance company: _____

Name of the policy holder: _____

Relationship to the policy holder (self, spouse, child, other) _____

Address of insurance company: _____
street city state zip

Ins. company phone #: _____ Adjuster's name: _____

Policy #: _____ Claim #: _____

Release and Assignment (please read and sign below)

I hereby consent and authorize the administration of all procedures. I hereby authorize Ridge Physical Therapy & Wellness Center to release or obtain any information to the insurance company, attorney, or referring physician upon request. I also assign and request payment of medical benefits to Ridge Physical Therapy & Wellness Center.

I also understand that I am financially responsible for any charges not covered by my insurance carrier.

Patient's Signature: _____ Date: _____

Please print your name: _____